CONFIDENTIAL INTAKE FORM Date: ______

GENERAL INFORMATION

Full name: ______ Name you prefer: ______

Gender Identity: ❑ Male ❑ Female ❑ Non-Conforming Date of birth: ______ Age: ______

Ethnicity: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic or Latino
❑ Native Hawaiian or Other Pacific Islander ❑ Two or More Races ❑ White ❑ Other ______

Referred by: ❑ Current/Former Client ❑ Northland ❑ Previous OCC Client ❑ Friend ❑ Google ❑ Other ______

Street address: ______ Suite/Apartment #: ______

City: ______ State: ______ Zip code: ______
May we send mail here: ❑ Yes ❑ No

Home Phone: ______ Call you here? ❑ Yes ❑ No Message here? ❑ Yes ❑ No

Work phone: ______ Call you here? ❑ Yes ❑ No Message here? ❑ Yes ❑ No

Cell phone: ______ Call you here? ❑ Yes ❑ No Message here? ❑ Yes ❑ No

Email: ______ Contact you here? ❑ Yes ❑ No

Employer: ______ How long have you worked there: ______

Occupation: ______ Average hours worked per week: ______

Highest level of education completed: ______ Are you currently in school? ❑ Yes ❑ No

If yes, what level? ______ Degree pursuing: ______

Are you related to or connected with any current RTS counseling student? ______

Religious Affiliation: ______ Do you regularly attend a place of worship? ❑ Yes (Where) ______ ❑ No

In case of emergency, contact:

Name: ______ Relationship: ______

Home phone: ______ Cell phone: ______

RELATIONAL INFORMATION

Relationship status: ❑ Cohabitating and unmarried ❑ Dating ❑ Divorced ❑ Engaged ❑ Married
❑ Partnered ❑ Separated ❑ Single ❑ Unsure ❑ Widowed

How long have you been this status? ____________________

Number of previous marriages for you? __________________ For your partner/spouse? ______________

Partner's/Spouse's name: _____________________________ Partner's/Spouse's age: _______________

Is your partner/spouse supportive of you seeking counseling? ❑ Yes ❑ No ❑ Unsure ❑ He/She doesn't know

With whom do you currently live? (*Check all that apply*) ❑ Alone ❑ Spouse ❑ Children ❑ Parent(s) ❑ Sibling(s)
❑ Boyfriend ❑ Girlfriend ❑ Roommate(s) ❑ Other: _______________

List your children (including step, adopted, foster, deceased) below:

Name	Sex	Age or year of death	Relationship to you	Living with whom?

Have you ever placed a child for adoption? ❑ Yes (When) ________________ ❑ No

Have you ever had a ❑ miscarriage or ❑ medical abortion? ❑ Yes (When) _____________ ❑ No

List your mother, father, brothers, sisters, step-family relations, or any other family member who had a significant effect (positive or negative) upon your life.

Name	Age or year of death	Relationship to you (e.g., mother, father, sibling, step-relation)	Give 2-3 words to describe this person

COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs: *(Use the back, if necessary)*

Therapist's name or program	Major issue(s)	Dates/Number of Sessions

MEDICAL HISTORY

List any medical conditions, illnesses, treatments, or surgeries:

____

____

____

Has your weight changed in the last 2-3 months and if so, why? ______________________________

Has there been a change in your eating patterns in the past/recent past and if so, why? ______________________

Do you have concerns about your weight and if so, what? ______________________________

Do others have concerns about your weight and if so, what? ______________________________

List all current medications you are taking, including those you seldom use or take only as needed:
(Use back if necessary)

Doctor & Name of medication	Dose	Reason for taking medication

Do things ever get so bad you think about ending your life or suicide? ❑ Yes ❑ No
Have you experienced them in the past? ❑ Yes ❑ No
Have you ever attempted suicide? ❑ Yes ❑ No
If Yes, when and how:

____

____

Have any of your ❑ friends or ❑ family ever attempted or died by suicide? ❑ Yes ❑ No
If yes, when and who:

____

____

Are you presently experiencing any thoughts of harming yourself or another person? Yes No

PRESENT ISSUES

Check any of the following symptoms or problems that you are presently experiencing or have experienced in the past.

Present	Past	Present	Past	Present	Past
❑	❑ Stress	❑	❑ Fears	❑	❑ Controlled by others
❑	❑ Anxiety or worry	❑	❑ Shyness	❑	❑ Obsessive thoughts
❑	❑ Panic	❑	❑ Low self-esteem	❑	❑ Compulsive behaviors
❑	❑ Depression	❑	❑ Don’t like myself	❑	❑ Seeing things others don’t see
❑	❑ Crying all the time	❑	❑ Marital problems	❑	❑ Hearing voices
❑	❑ Lack of motivation	❑	❑ Other relational problems	❑	❑ Racing thoughts
❑	❑ Fatigue/Lack of energy	❑	❑ Parenting stress	❑	❑ Eating problems
❑	❑ Poor appetite or overeating	❑	❑ Physical abuse	❑	❑ Drug use
❑	❑ Trouble sleeping	❑	❑ Emotional abuse	❑	❑ Alcohol use
❑	❑ Poor concentration	❑	❑ Verbal abuse	❑	❑ Pregnancy
❑	❑ Feeling worthless or inferior	❑	❑ Sexual abuse	❑	❑ Abortion
❑	❑ Feeling hopeless	❑	❑ Sexual problems	❑	❑ Legal matters
❑	❑ Guilt	❑	❑ Gender identity	❑	❑ Work stress
❑	❑ Death of friend or loved one	❑	❑ Anger	❑	❑ Career choices
❑	❑ Grief	❑	❑ Aggressive behavior	❑	❑ Indecisiveness
❑	❑ Chronic pain	❑	❑ Bad dreams	❑	❑ Lack of discipline
❑	❑ Physical disability	❑	❑ Unwanted memories	❑	❑ Financial problems
❑	❑ Terminal illness	❑	❑ Loss of control	❑	❑ Spiritual apathy
❑	❑ Health concerns	❑	❑ Impulsive behavior	❑	❑ Other ____________________
❑	❑ Loneliness	❑	❑ Controlling		

Please mark on the scale below to indicate how distressing your problem(s) are to you.

|———————————————————————————————————————|

Minimally Distressing	Moderately Distressing	Extremely Distressing

Please describe why you are coming to counseling *(i.e., what are your issues, problems?)*:

____

____

Why have you decided to come for counseling now?

____

____

What do you hope to gain or change by coming for counseling?

____

____

How will you know you accomplished your goals?

____

____

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full administrative fee for service.

Signed: ____ Date:________________________